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HOUSE BILL NO. 1526

Offered January 27, 2026

A BILL to amend and reenact § 38.2-3407.15:8, as it shall become effective, of the Code of Virginia and to amend and reenact the second enactment of Chapters 474 and 475 of the Acts of Assembly of 2023, relating to health insurance; prior authorization; required contract provisions.

Patron—Fowler

Unanimous consent to introduce

Referred to Committee on Labor and Commerce

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3407.15:8, as it shall become effective, of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3407.15:8. (Effective January 1, 2027) Carrier contracts; required provisions regarding prior authorization for health care services.

A. As used in this section:

"Carrier" has the same meaning as provided in subsection A of § 38.2-3407.15.

"Expedited" means, in relation to a health care service or a prior authorization request for a health care service, that the delay of such service could seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

"Health care services" has the same meaning as provided in § 38.2-3407.15, except that as used in this section, "health means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability, including medical items and services. "Health care services" does not include drugs that are subject to the requirements of § 38.2-3407.15:2.

"Prior authorization" means the approval process used by a carrier before certain health care services may be provided.

"Provider" has the same meaning as provided in § 38.2-3407.10.

"Provider contract" has the same meaning as provided in subsection A of § 38.2-3407.15.

"Standard" means, in relation to a health care service or a prior authorization request for a health care service, that such health care service or prior authorization request is not expedited.

"Supplementation" means a request communicated by the carrier to the provider or his designee for additional information, limited to items specifically requested on the applicable prior authorization request, necessary to approve or deny such request.

B. Any provider contract between a carrier and a participating health care provider or its contracting agent shall contain specific provisions that:

1. Require that the carrier communicate electronically or telephonically to the provider or his designee within 72 hours, including weekend hours, of submission of an expedited prior authorization request to the carrier that the request is approved, denied, or requires supplementation;

2. Require that the carrier communicate electronically or telephonically to the provider or his designee within seven calendar days of submission of a standard prior authorization request to the carrier that the request is approved, denied, or requires supplementation;

3. Where supplementation is required, require the carrier to specify to the provider or his designee the supplementation necessary for the carrier to make a final determination that the request is approved or denied, and following properly completed supplementation from the provider or his designee, require the carrier to approve or deny the request within the timeframes specified in subdivisions 1 and 2;

4. Require that if a prior authorization request is approved for health care services and such health care services have been scheduled or provided to the enrollee consistent with the authorization, the carrier shall not revoke, limit, condition, modify, or restrict that authorization unless (i) the provider requests a change, (ii) there is evidence that the authorization was obtained based on fraud or misrepresentation, or (iii) a final action by a federal regulatory agency or the manufacturer removes an approved health care service from the market, limits its use in a manner impacting the prior authorization, or communicates a patient safety issue that would impact the prior authorization. Nothing in this section shall require a carrier to authorize any health care service if the enrollee is no longer enrolled in the health plan; and

5. Require that if the prior authorization request is denied, the carrier shall communicate electronically or telephonically to the provider or his designee within the timeframes established by subdivision 1 or 2, as applicable, the reasons for the denial;

6. Require a carrier to establish and maintain a prior authorization application program interface as

59 *described in 42 C.F.R. § 422.122(b) for processing prior authorization requests from providers for medical*
 60 *items and services that aligns with the requirements and standards for impacted payers under plan and*
 61 *product types regulated by the U.S. Centers for Medicare and Medicaid Services. A carrier shall implement*
 62 *such prior authorization application program interface by January 1, 2027, or any other effective date*
 63 *subsequently issued by the Centers for Medicare and Medicaid Services, including those related to*
 64 *enforcement delays and suspensions; and*

65 *7. Require a participating health care provider, within one year after the date required for implementing*
 66 *a prior authorization application program interface pursuant to subdivision 6, to ensure that any electronic*
 67 *health record or health information technology system owned by or contracted for the provider to maintain*
 68 *the health record of an enrollee has the ability to access such application program interface. A provider may*
 69 *request a waiver of compliance under this subdivision for undue hardship for a period determined by the*
 70 *appropriate regulatory agency of the Secretariat of Health and Human Resources.*

71 *C. If a carrier requires prior authorization for certain health care services to be covered, the carrier shall*
 72 *make available through one central location on the carrier's publicly accessible website or other electronic*
 73 *application the list of services and codes for which prior authorization is required. A carrier ~~must~~ shall notify*
 74 *providers at least 30 calendar days in advance of the effective date of any changes to the list of prior*
 75 *authorization requirements and update the publicly accessible list of services and codes for which prior*
 76 *authorization is required by the effective date of any new requirement. All of the carrier's prior authorization*
 77 *procedures and all prior authorization request forms accepted by the carrier shall also be made available and*
 78 *updated by the carrier on the publicly accessible website or other electronic application by the effective date*
 79 *of any new requirements. The carrier shall also indicate the effective date of the prior authorization*
 80 *requirements for each service on the list, including those services where prior authorization is performed by*
 81 *an entity under contract with the carrier, provided, however, that if the prior authorization was already*
 82 *required prior to January 1, 2027, the carrier may indicate an effective date of January 1, 2027.*

83 *D. A carrier shall not deny a claim for failure to obtain prior authorization if the prior authorization*
 84 *requirements for the date of service were not posted on the publicly accessible website or other electronic*
 85 *application in accordance with subsection C.*

86 *E. Nothing in this section shall prohibit a carrier from removing prior authorization requirements without*
 87 *the 30-day notice period to providers in the event of a pandemic, a natural disaster, or any other emergency*
 88 *situations.*

89 *F. Each carrier shall make available by posting on its website no later than March 31 of each year the*
 90 *prior authorization data for prior authorizations covered by this section for the previous calendar year at the*
 91 *health plan level for all metrics required for compliance with federal law and the regulations of the Centers*
 92 *for Medicare and Medicaid Services, including those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f),*
 93 *440.230(e)(3), and 457.732(c).*

94 *G. Notwithstanding any law to the contrary, no provision of this section shall apply to any health*
 95 *maintenance organization that (i) contracts with a multispecialty group of physicians who are employed by*
 96 *and are shareholders of such multispecialty group, which multispecialty group may also contract with health*
 97 *care providers in the community, and (ii) provides and arranges for the provision of physician services by the*
 98 *physician members of such multispecialty group or by such contracted health care providers.*

99 *H. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this*
 100 *section.*

101 *I. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and*
 102 *regulations as it may deem necessary to implement this section.*

103 **2. That the second enactment of Chapters 474 and 475 of the Acts of Assembly of 2023 is amended and**
 104 **reenacted as follows:**

105 **2. That the State Corporation Commission's Bureau of Insurance (the Bureau) shall, in**
 106 **coordination with the Secretary of Health and Human Resources, establish a work group to (i) monitor**
 107 **~~anticipated federal developments related to the implementation of electronic prior authorization for~~**
 108 **~~medical items and services, (ii) assess pursuant to § 38.2-3407.15:8 of the Code of Virginia, including any~~**
 109 **~~relevant federal developments, industry progress and readiness to implement electronic prior~~**
 110 **~~authorization for medical items and services, and (iii) evaluate policies supporting the effective and~~**
 111 **~~efficient adoption of electronic prior authorization for medical items and services; (ii) monitor and~~**
 112 **~~consider options for revising the prior authorization process for prescription drugs from a less~~**
 113 **~~retrospective to a more prospective process; and (iii) consider whether the scope of prior authorization~~**
 114 **~~metrics reporting described in § 38.2-3407.15:8 of the Code of Virginia should be expanded to include~~**
 115 **~~prescription drugs, recognizing the practical aspects of implementation on a timeline consistent with~~**
 116 **~~medical items and services, the uncertainty around the timeline for any federal action and the form any~~**
 117 **~~such reporting might take, and the desire to conform any state requirements to those adopted at the federal~~**
 118 **~~level. The work group shall include relevant stakeholders, including representatives from the Virginia~~**
 119 **~~Association of Health Plans, the Medical Society of Virginia, the Virginia Hospital and Healthcare~~**
 120 **~~Association, the Virginia Pharmacists Pharmacy Association, and other interested parties with an~~**

121 ~~interest in the underlying technology.~~ The work group shall report its findings and recommendations
122 to the ~~Chairmen~~ *Chairs* of the Senate Committees on Commerce and Labor and Education and Health
123 and the House Committees on *Labor and Commerce* and ~~Energy~~ and Health, ~~Welfare and Institutions~~
124 and Human Services annually by November 1 and shall make its final report by November 1, 2028. ~~In~~
125 ~~its November 1, 2025 report, the work group shall provide a final assessment of progress toward~~
126 ~~implementing electronic prior authorization and real-time cost benefit information for prescription~~
127 ~~drugs in the Commonwealth and shall recommend a date by which health carriers and providers shall~~
128 ~~implement electronic prior authorization for medical items and services.~~

INTRODUCED

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